

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155745		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2011	
NAME OF PROVIDER OR SUPPLIER HOLY CROSS VILLAGE AT NOTRE DAME INC				STREET ADDRESS, CITY, STATE, ZIP CODE 54515 STATE ROAD 933 NORTH NOTRE DAME, IN46556			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/14/11</p> <p>Facility Number: 002668 Provider Number: 155745 AIM Number: 200325990</p> <p>Surveyor: Richard D. Schade, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Holy Cross Village at Notre Dame, Inc. was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The original building was built in 1964 with the Dujarie Wing added in 1980, the Murphy Wing in 1985 and the Quinn Wing, which is a</p>			K0000	<p>Holy Cross Village at Notre Dame, Inc., (the "Provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the provider determines that the disputed finding: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services, ("CMS"), the state of Indiana or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any Changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155745		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2011	
NAME OF PROVIDER OR SUPPLIER HOLY CROSS VILLAGE AT NOTRE DAME INC				STREET ADDRESS, CITY, STATE, ZIP CODE 54515 STATE ROAD 933 NORTH NOTRE DAME, IN46556			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0052 SS=C	<p>noncertified comprehensive care unit, in 2007. The facility has a fire alarm system with smoke detection in the corridors, resident sleeping rooms and spaces open to the corridors. The facility has a capacity of 48 and had a census of 43 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/22/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on interview and record review, the facility failed to provide consistent evidence of the complete testing, maintenance and inspection of 1 of 1 fire alarm systems. LSC 9.6.1.4 refers to NFPA 72, National</p>			K0052	<p>that basis. Please accept this plan of correction as our credible allegation of compliance for the Life Safety Survey conducted by the Indiana State Department of Health of 07/14/2011.</p> <p>K 052 101 NFPA LIFE SAFETY CODE</p> <p>Plan of Correction Holy Cross Village has hired</p>		08/08/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155745		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/14/2011	
NAME OF PROVIDER OR SUPPLIER HOLY CROSS VILLAGE AT NOTRE DAME INC				STREET ADDRESS, CITY, STATE, ZIP CODE 54515 STATE ROAD 933 NORTH NOTRE DAME, IN46556			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Fire Alarm Code. NFPA 72, 7-1.1.1 requires fire alarm systems shall be inspected, tested and maintained. This deficient practice effects all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>During the alarm systems record review with the maintenance supervisor and facility administrator on 07/14/11 at 1:10 p.m., the number of documented devices inspected annually by FAST was not consistent from inspection to inspection. The number of devices inspected in 2008 was 281; in 2009, 288 devices were tested; in 2010, 289 devices were tested; and in 2011 the report indicated there were 291 devices. The maintenance supervisor stated at the time of record review, he did not have an explanation for the increase of 10 devices between 2008 and 2011.</p> <p>3.1-19(b)</p>				<p>ESCO Communications to audit the devices and retest all devices. ESCO Communications was the original installer of the fire alarm system. ESCO Communications is a certified installer and tester of this type of system. Re-test of this system is scheduled for August 8, 2014</p> <p>Director of Plant Operations will monitor annual reports to ensure that the correct number of devices are correct and from report to report.</p> <p>Director of Plant Operations will report findings to CQI Committee</p> <p>K 052 MICELLANEOU S</p> <p>Plan of Correction A. Attached copy of contract with ESCO Communications and Holy Cross Village for 3-year term.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155745		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2011	
NAME OF PROVIDER OR SUPPLIER HOLY CROSS VILLAGE AT NOTRE DAME INC				STREET ADDRESS, CITY, STATE, ZIP CODE 54515 STATE ROAD 933 NORTH NOTRE DAME, IN46556			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0143 SS=E	<p>Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage areas were provided with signage indicating oxygen transferring is occurring. This deficient practice could affect residents, staff and visitors in and near the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the facility maintenance supervisor and facility administrator during the tour of the facility at 1:35 p.m. on</p>			K0143	<p>K 143 NFPA 101 LIFE SAFETY CODE CORRECTIVE ACTION</p> <p>Plan of Correction Temporary transfer sign was installed on July 15, 2011 at oxygen room.</p> <p>In-service was conducted with nursing staff for utilization of temporary oxygen sign.</p> <p>Permanent sign will be installed on July 25, 2011. The new sign includes a slider that indicates transferring of oxygen is</p>		07/25/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155745		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2011	
NAME OF PROVIDER OR SUPPLIER HOLY CROSS VILLAGE AT NOTRE DAME INC				STREET ADDRESS, CITY, STATE, ZIP CODE 54515 STATE ROAD 933 NORTH NOTRE DAME, IN46556			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0144 SS=F	07/14/11, the facility's oxygen storage and transfilling room was not provided with a sign indicating transferring of oxygen was occurring. Based on interview at the time of observation, the maintenance supervisor acknowledged the transferring of oxygen does occur in the oxygen storage and transfilling room and no sign indicating the transferring of oxygen was occurring in the facility's oxygen storage and transfilling rooms was provided.			K0144	occurring. In-service was conducted with nursing staff on the proper use of transfer sign.		08/13/2011
	3.1-19(b) Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure the generator ran for at least 30 minutes at 30% of the nameplate rating for 12 of 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical				K 144 NFPA 101 LIFE SAFETY CODE CORRECTIVE ACTION Plan of Correction · Load test was conducted by MacAllister		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155745		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2011	
NAME OF PROVIDER OR SUPPLIER HOLY CROSS VILLAGE AT NOTRE DAME INC				STREET ADDRESS, CITY, STATE, ZIP CODE 54515 STATE ROAD 933 NORTH NOTRE DAME, IN46556			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of monthly load test record documentation with the maintenance supervisor and facility administrator at 12:50 p.m. on 07/14/11, monthly logs for the</p>				<p>Machinery on July 21, 2011 for 90 minutes under load. The finding of this test indicated that the generator is only operating on 23% of load. Bank load test is scheduled with MacAllister Machinery on August 13, 2011. Load test will meet or exceed the 30% load test of NFPA 101 Life Safety Code.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/09/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155745		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 07/14/2011	
NAME OF PROVIDER OR SUPPLIER HOLY CROSS VILLAGE AT NOTRE DAME INC				STREET ADDRESS, CITY, STATE, ZIP CODE 54515 STATE ROAD 933 NORTH NOTRE DAME, IN46556			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	period of July 2010 through July 2011 show the emergency generator was not tested at 30 percent of the capacity of the nameplate rating for the last year. Based on interview at the time of record review, the maintenance supervisor stated he was aware of the requirement and thought the procedure was being completed. 3.1-19(b)						